

Service	Pre-3	Pre-4	K	1	2	3	4	5	6	7	8	9	10	11	12	Referrals	Transfer Students	Known Problems
Preventative Health Exam	Xm	Xm	Xm						Xm			Xm*					Xm	
Immunization Record	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	
Eye Exam	Xm	Xm	Xm														Xm	
Cumulative Record	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm		Xm	
Athletic/Sports Physicals++										Xm	Xm	Xm	Xm	Xm	Xm		Xm	
Scoliosis Screening									Xm		Xm							
Vision Screening						Xs		Xs								Xs		Xs
Hearing Screening			Xs	Xs	Xs	Xs										Xs	Xs	Xs
Height & Weight			Xs	Xs	Xs	Xs	Xs	Xs	Xs			Xs						
T.B. Skin Test			R														R	

- Xm-Mandated in 704 KAR 4:020 Section 2: (1) A local board of education shall require a preventative health care exam of each child within one (1) year prior to the child's initial admission to school. A second exam shall be required within one (1) year prior to entry into the sixth grade or initial admission to school. (3) A local school board may exceed the deadline by which to obtain a preventative health care exam no to exceed two (2) months. (9) A valid immunization certificate shall be on file within two (2) weeks of the child's enrollment in school. A preventative health care exam may be performed and signed for by a physician, and advanced registered nurse practitioner, a physician's assistant or a health care provider in the early periodic screening diagnosis and treatment programs.
- **Eye exam:** KRS 165.160: (g) A vision examination by an optometrist or ophthalmologist that shall be submitted to the school no later than January 1 of the first year that a child is enrolled in a public school, public preschool or Head Start
- Xm* 704 KAR 4:020 Section "A third exam may be required by policy of the local school board within 1 year prior to entry into the ninth grade or initial school entry"
- ++ Athletic/Sports Physicals must be given by a Physician, Physician Assistant, Advanced Registered Nurse Practitioner or Chiropractor. The exam is valid for one (1) year from the examination date. (KRS 156.070; HSAA Handbook Bylaw 2)
- R- As Recommended. 704 KAR Section 2 (10) TB testing shall be carried out upon notification by a local health department.

- Xs Suggested as appropriate intervals for provision of those services. Scoliosis Screening, Vision Screening, Hearing Screening, Height & Weight: 704 KAR Section 2 (11) A board of education shall adopt a program of continuous health supervision for all school enrollees. Supervision shall include scheduled, appropriate screening tests for vision, hearing and scoliosis. (11) (c) Established scoliosis screening times, at least in grade six (6) and eight (8) and appropriate procedures and referral criteria
- Cumulative Health Records 704 KAR Section 3 (1) A school shall initiate a cumulative health record for each pupil entering its school. The record shall be maintained throughout the pupil's attendance. The record shall include screening tests related to growth and development, vision hearing, and scoliosis and findings and recommendations of a physician and a dentist
- This Matrix of Health Services addresses only the health services required by Kentucky Law or Administrative Regulation. Individual school districts may choose to add additional screenings according to their school district policies.

COMMONWEALTH OF KENTUCKY
IMMUNIZATION CERTIFICATE



(Required of each child enrolled in a public or private school, preschool program, day care center,
certified family child care home, or other licensed facility which cares for children.)

Name of Child _____ Birthdate _____
(Last) (First) (Middle)

Name of Parent or Guardian _____

Address _____
(Street) (City) (State) (Zip Code)

DATES ADMINISTERED (month/day/year)

DIPHTHERIA, TETANUS, PERTUSSIS* #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___

POLIO VACCINES #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

MMR (Measles, Mumps, Rubella)** #1 ___/___/___ #2 ___/___/___ Other ___/___/___ Other ___/___/___

Hib*** #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

Hepatitis B**** #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ or #1 ___/___/___ #2 ___/___/___ (adult dose)

Varicella ***** #1 ___/___/___ or child has had chickenpox disease (X) _____.

*DTaP, DTP, DT, Td **MMR for one dose, measles-containing for second. ***Hib not required at age 5 years or more. **** Alternative two dose series of approved adult hepatitis B vaccine for children 11-15 years of age. *****Varicella required for children 19 months to 7 years unless a parent, guardian or physician states that the child has had chickenpox disease.

This child is current for immunizations until ___/___/___, (two weeks after the next shot is due) after which this certificate is no longer valid and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

Signature of physician, Health Dept., or their designee _____ Date _____

This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record. EPID-230 (Rev 8/2002)

COMMONWEALTH OF KENTUCKY
CERTIFICATE OF MEDICAL EXEMPTION



Name of Child _____ Birthdate _____
(Last) (First) (Middle)

Name of Parent or Guardian _____

Address _____
(Street) (City) (State) (Zip Code)

MEDICAL EXEMPTION – THE ABOVE NAMED CHILD HAS CERTAIN SPECIFIC HEALTH/PHYSICAL CONDITIONS WHICH ARE RECOGNIZED CONTRAINDICATIONS TO THE ADMINISTRATION OF ONE OR MORE OF THE REQUIRED VACCINES:

VACCINE(S) CONTRAINDICATED _____
DATES ADMINISTERED (month/day/year)

DIPHTHERIA, TETANUS, PERTUSSIS* #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____

POLIO VACCINES #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____

MMR (Measles, Mumps, Rubella)** #1 ____/____/____ #2 ____/____/____ _____/____/____
Other Other

Hib*** #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____

Hepatitis B**** #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ or #1 ____/____/____ #2 ____/____/____ (adult dose)

Varicella***** #1 ____/____/____ or child has had chickenpox disease (X) _____.

*DTaP, DTP, DT, Td **MMR for one dose, measles-containing for second. ***Hib not required at age 5 years or more. **** Alternative two dose series of approved adult hepatitis B vaccine for children 11-15 years of age. *****Varicella required for children 19 months to 7 years unless a parent, guardian or physician states that the child has had chickenpox disease. This child is current for immunizations until ____/____/____, (two weeks after next shot is due) after which this certificate is no longer valid and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

Signature of physician, Health Dept., or their designee _____ **Date** _____

This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.
EPID-230B (Rev 8/2002)

COMMONWEALTH OF KENTUCKY
CHILDHOOD IMMUNIZATION LAW
CERTIFICATE OF RELIGIOUS EXEMPTION



Name of Child _____ Birthdate _____

(Last) (First) (Middle)

Name of Parent or Guardian _____

Address _____

(Street) (City) (State) (Zip Code)

RELIGIOUS EXEMPTION – THE ABOVE NAMED CHILD IS HEREBY GRANTED A RELIGIOUS EXEMPTION OBJECTING TO _____ IMMUNIZATION(S) ON RELIGIOUS GROUNDS. A SWORN STATEMENT FROM THE PARENT OR GUARDIAN IS ATTACHED.

(Signature of physician, health dept., or their designee)

(Date)

(Address)

This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

EPID-230C (Rev 09/2002)

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

Physical Exam:

N.	Abn.	
_____	_____	General Appearance
_____	_____	HEENT
_____	_____	Skin
_____	_____	Neck
_____	_____	Chest
_____	_____	Heart
_____	_____	Abd - Genitalia
_____	_____	Extremities-Back
_____	_____	Neuro_

Hgt: _____ Wgt: _____ BP: _____ / _____

Hearing: R _____ L _____

Vision: R _____ / _____ L _____ / _____

STRABISMUS/AMBLYOPIA SCREEN ☐ ABNORMAL

Optional-----HCT/HGB: _____ (required for headstart)

Optional-----UA: _____

Explain Abnormal Exam: _____

Recommendations:

_____ No Restrictions: Normal Exam

_____ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: _____

Age appropriate and suggested anticipatory guidance (health assessments)

- ☐ Discuss injury prevention with parents
- ☐ Bicycle Safety ☐ Car Seat Belts ☐ Memorization of Name, Address and Phone Number
- ☐ Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.
- ☐ Emphasize the importance of dental care.
- ☐ Discuss mental health issues.

Signed: _____ Date: _____

Physician/ARNP/PA/EPSTD Provider

Address: _____ Telephone: _____

Kentucky Department of Education

PREVENTATIVE HEALTH CARE EXAMINATION FORM - Sixth (6th) Grade Form (for grades 5-12)

All local boards of education shall require a second and third preventative health care examination of each child within one (1) year prior to entry into the sixth (6th) grade or subsequent grades. Each board shall have an approved program of continuous health supervision in accordance with current statutes and regulations, vision, hearing and scoliosis scheduled screening tests. Local school districts shall establish a plan for implementation and compliance with the sixth (6th) grade examination.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Grade: 5th 6th 7th 8th 9th 10th 11th 12th (Circle appropriate grade)

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

Physical Exam:

N.	Abn.		
_____	_____	General Appearance	Hgt: _____ Wgt: _____ BP: _____ / _____
_____	_____	HEENT	Hearing: R _____ L _____
_____	_____	Skin	Vision: _____ R _____ / _____ L _____ / _____
_____	_____	Neck	Optional-----HCT/HGB: _____
_____	_____	Chest	Optional-----UA: _____
_____	_____	Heart	
_____	_____	Abd-Genitalia	
_____	_____	Extremities-Back (including scoliosis screen for 6 th grade)	
_____	_____	Neuro	

Explain Abnormal Exam: _____

Recommendations:

_____ No Restrictions: Normal Exam

_____ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: _____

Age Appropriate and Suggested Anticipatory Guidance (Health Assessments)

- How have things been going for you at school? With your peers?
- How do you rate your own health?
- What concerns do you have about your own development?

Advise adolescents about the following good health habits and self-care. – See sample reference on back of form.

☐ Risk behaviors were discussed and addressed

☐ Risk behaviors were not addressed today

Signed: _____ Date: _____
Physician/ARNP/PA/EPSTD Provider

Address: _____ Telephone: _____

Guidelines Only - Please do not mark risk factors on this form.

	Low Risk	Moderate Risk	High Risk
Body Mass Index	Between 15-85% Normal weight/height per the growth chart	Between 5-15%/85-95% (Just over or just under the normal range)	<5%/>95% (Much over or much under normal weight)
Weight perception	Feels good about weight	Feels “fat” even though weight is normal on the chart	Skips meals, vomits, takes medicine, or exercises too much to control weight
Nutrition	Eats 3 meals/day; and eats fruits, vegetables, and foods with fiber	Eats less than 3 meals/day; or vegetarian without milk or eggs	Eats a lot of snacks with fat and sugar, eats few regular meals
Exercise	5 times/week for at least 20 min each, with increased heart rate and sweating	Exercises less than 5 times/week, not strenuously	No regular exercise to increase heart rate
Tobacco use	No smoke or chew	Smoke or chew less than daily; or Stopped less than 6 weeks ago	Smoke or chew regularly
Drug use	Never used	Previously used; not in the past 3 months	Recently used or currently uses marijuana, huffing, LSD, cocaine, heroin, etc.
Alcohol use	Has only tasted it, or used for religious purpose	Social only, not more than once/week; less than 3 beers or 2 liquor drinks at a time	Drunkenness, blackouts; drinking interferes w/school, family, etc.; 4 or more drinks at a time
Sexual activity	Never, or is married and faithful	Not in last 6 months; safe sex with condoms	Sex <u>without</u> regular use of condoms; first intercourse before age 16
School	B/C average or better, steady improvement in grades	Grades slipping; detention problem	Failing grades; suspension; often skips school
Depression	Usually happy	Often feels discouraged or down; cries a lot	Unhappy <u>most</u> of the time; feels hopeless; thought of suicide
Abuse	No physical or sexual abuse	Abuse reported and counseling received	Abuse still occurring or not treated with counseling
Safety	Uses seat belt/helmet, never rides with drunk driver	Usually uses seat belt/helmet; rarely rides with drunk driver	Does not use seat belt/helmet; has driven drink; sometimes rides with drunk driver
Violence	No fights, no threats, does not carry a knife, gun, or rifle, no legal troubles	Threatens others; previous illegal acts (stealing, etc.) but not in past 3 months	Damages own or others' property; carries a gun, knife, or rifle; physical fights with peers; has had contact with police
Family relationships and responsibility	Gets along with family, completes chores or work duties	Often argues with family; does not complete chores or work duties	Physical and/or intense verbal fights with family
Friends and Recreation	Has male and female friends; involved in clubs, activities, or hobbies	Has few friends; does things alone; has friends who often get into trouble	Has no friends; or belongs to gang or cult
Good qualities and Future plans	Can name 3 good qualities about self; has plans for the future	Hard to think of good qualities about self; has few interests; does not have future	No good qualities about self; no interests or activities
Immunizations	Second MMR; tetanus within ten years; hepatitis series; had varicella or been vaccinated	Lacks any one item	Lacks two or more items

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230

CASE HISTORY

Date of Exam: _____

Ocular History: Normal ☐ or Positive for: _____

Medical History: Normal ☐ or Positive for: _____

Drug Allergies: NKDA ☐ or Allergic to: _____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes
Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (please indicate one) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20 / _____	20 / _____
Best Corrected Acuity	20 / _____	20 / _____
	Normal Abnormal Not able to Assess	

External Exam (eye and adnexa)

☐ ☐ ☐

Internal Exam (media, lens, fundus, etc)

☐ ☐ ☐

Neurological Integrity (pupils)

☐ ☐ ☐

Binocular Function (stereopsis)

☐ ☐ ☐

Accommodation and convergence

☐ ☐ ☐

Color Vision

☐ ☐ ☐

Diagnosis: ☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

☐ Educate (parents/patients) about eye/vision disorders and needed vision care

☐ Counsel (parents/patients) regarding eye safety

☐ Stress importance of early, preventative eye care

☐ Recommend re-examination, as appropriate

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: () _____

KENTUCKY HIGH SCHOOL ATHLETIC ASSOCIATION
2280 Executive Drive, Lexington, Kentucky 40505
Athletic Participation/Parental Consent/Physical Examination Form

PART I - ATHLETE INFORMATION

(To be completed by athlete)

Name: _____ School Year _____
(Last) (First) (Initial)

Home Address: _____
(Street) (City, State, zip)

Date of Birth: _____ Birth Place (County, State): _____

This is my _____ year at _____ School and my
_____ year since entering ninth grade. Last year I attended _____

School. I am planning to participate in the following (circle all you might try to play):

Baseball Cross Country Golf Softball Tennis Volleyball
Basketball Football Soccer Swimming Track Wrestling
Cheerleading Field Hockey Other:

PART II - MEDICAL HISTORY

This form must be completed by parent and athlete prior to the time of the physical exam and presented to the authorized health care provider before the physical.

CHECK THE APPROPRIATE RESPONSE TO EACH ITEM:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery of any kind (e.g., tonsillectomy). | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies (medicine, bees, or other insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has anyone in your family died of heart problems before 50?. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any skin problems? (itching, rashes, acne) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure or suffer from epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had heat related problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been dizzy or passed out in the heat?. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you cough heavily, or breath heavily during activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use any special equipment (e.g., knee brace)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any problems with your eyes or vision?. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you missing one of any paired organs (e.g., eyes) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever been diagnosed with any form of asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you using an inhaler for asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you diabetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you administer insulin to yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you presently using tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have a history of sickle-cell anemia in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had any other medical problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had a medical problem or injury within the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Can you swim? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. When was your last tetanus shot? | | |

Please explain any YES answers from questions 1-18. _____

PART III - PHYSICAL EXAMINATION

NAME: _____ SEX _____
SCHOOL: _____ GRADE _____
HEIGHT: _____ WEIGHT _____ BP _____ / _____ PULSE _____
VISION: R- 20/ _____ L- 20/ _____ BOTH- 20/ _____ CORRECTED? Y N

	Normal	Abnormal	Comment
HEART			
Rhythm (Regular/Irregular)			
Murmur (supine)			
Murmur (standing)			
ENT			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Dental			
Other			

I have reviewed the data above, reviewed the student's medical history and make the following recommendations on participation in athletics:

1. Cleared _____
2. Cleared after additional evaluation for _____
3. Restricted from participating in the sports of _____
4. Cleared to participate in the sports of _____

Recommendations/Restriction _____

In accordance with KHSAA Bylaws, I have examined the physical condition of the student and find the said pupil to be physically fit to practice for and participate in interscholastic athletic contests.

Authorized Signature _____ Date _____

Authorized Provider's Name (please print) _____

Address _____ Phone _____

Date _____ City, State, Zip _____

PART IV - ACKNOWLEDGMENT OF RISK, STATEMENT OF HAZARDS IN PARTICIPATION IN ATHLETICS AND PARENTAL CONSENT

The student athlete and the parent/guardian should read this statement carefully. You should be aware that playing or practicing to play or helping with or participating in any manner in any sport can be a dangerous activity involving many risks of injury. The dangers and risks of playing, practicing to play, helping or participating in sports include, but are not limited to, death, serious neck, head and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of the body, general health and well being. Because of the dangers of participating in sports, the student should recognize the importance of following the coaches' instructions regarding playing techniques, training and other team rules and obey such instruction.

In accordance with the purpose and spirit of KHSAA Bylaws, I acknowledge receipt of the included eligibility rules as put forth by the KHSAA and Kentucky Board of Education and understand additional rules may apply to my child. I also am aware of the risk of a wide range of injuries to my child as a result of participation in sports, with contact sports having a higher risk.

In accordance with the purpose and spirit of Kentucky High School Athletic Association Bylaws, Physician's Certificate and Parental Consent, I acknowledge receipt of the the current year's eligibility rules as promulgated by the Association and Kentucky Board of Education regulations. I understand that my child must have insurance coverage up to a limit of \$25,000 in order to be eligible to try for a place on an athletic team with the company listed below. I give consent for my son/daughter to represent his/her high school in interscholastic athletic contests for one calendar year from the date of this physical examination in the sport(s) checked below:

He/she is planning to participate in the following (circle all you might try to play):

Baseball	Cross Country	Golf	Softball	Tennis	Volleyball
Basketball	Football	Soccer	Swimming	Track	Wrestling
Cheerleading		Other: _____			

I also give my consent and approval for this student-athlete to receive a physical examination, as required by the KHSAA and acknowledge the risks inherent with participation.

Please complete both sides of this form, detach it from the Eligibility Rules and Regulations, and return it to the Principal of your high school immediately. I understand this **must** be done before my child practices or participates in any one of the above listed sports. I also understand the personal safety of the student is of first importance to the school. In event of needed professional medical care, I give my permission for a representative of the school to transport my child to the nearest medical facility and for staff of that facility to render treatment.

(To be completed and signed by parent/guardian)

Signature of Parent/Guardian

Date

Student's Name

High School

Parent's Name (please print)

Address

Phone No.

Insurance Carrier

Insurance Policy Number

Students desiring to participate in Wrestling must also complete KHSAA Form WR101 and required attachments between October 15 and December 15.

PART V. ATHLETES' ACKNOWLEDGMENT OF RISK AND PARTICIPATION

As an athlete I recognize the importance of following coaches instructions regarding playing techniques, training and other team rules, etc., and agree to obey such instruction in order to be safe and try to avoid injury. I also give school representatives permission to release my demographic information and playing or participation statistics and other information as may be requested, and agree that I may be photographed or otherwise captured during competition and such image may be used without my permission.

Signature of Athlete

PART VI - EMERGENCY PERMISSION FORM

(To be completed by parent / guardian)

STUDENT NAME _____

SOC. SEC. NO _____

ADDRESS _____

CITY/STATE/ZIP _____

SCHOOL _____

BIRTH DATE _____

PHONE _____

PERSON TO CONTACT IN CASE OF MEDICAL EMERGENCY:

NAME _____

RELATION _____

ADDRESS _____

CITY/STATE/ZIP _____

DAYTIME PHONE _____

EVENING PHONE _____

Please list any health problems/concerns your child may have, including allergies (medications / others) and any medications presently being used: _____

In the event that an athletic injury should occur to the above named student-athlete I give my permission for them to receive proper/necessary care from a certified athletic trainer or coach employed by or representing _____ School.

Furthermore, in the event that a medical emergency should occur and I cannot be contacted I give my permission for a school representative (coach, athletic trainer) to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render treatment which is considered necessary for the student-athletes well being.

Parent/Guardian Signature: _____

Date: _____

Emergency permission form must be reproduced to travel with respective athlete and is acceptable for emergency treatment.

Physical Exam Valid for One Year from Date Administered.

Physical Exam must be signed by authorized Health Care Providers named in Bylaw 2.

Name _____ Date of Birth _____ Physical Examination(s) _____

(Last) (First) (Middle)

Health conditions such as severe allergies, disabilities, chronic illness, or other special health needs (Add comments on back.) _____

504/IEP Date of Review or Reevaluation _____

Screening Record

Record date of screening and student's age with each screening result. *Indicate with an asterisk if student is wearing glasses during vision screening.

[illegible]

DOCUMENTATION

Use this side to record referrals and follow-ups (*physician, clinic, parent, etc.*), special procedures required during the school day, or other significant findings that may affect the student's school participation. Please sign and date all entries.

PUPIL'S CUMULATIVE HEALTH RECORD

The purpose of this record is to give the health professional a concise summary of the student's school health history. It is not intended to be used for daily documentation. Parent and emergency information should be maintained elsewhere.

Screenings are recorded by date and student age rather than grade level. This accommodates changes in the primary program and documents the information more accurately for the student.

The reverse side of the form is designed to allow school personnel ample space to document other information pertinent to the school health program.

SCHOOL SCREENING FOR SCOLIOSIS

Screening Procedure Worksheet

SIDE VIEW



Upper back
Normally
Rounded, Neck
Erect, Chin In,
Head in Balance

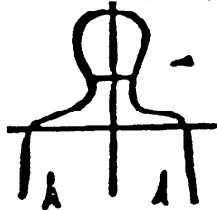


Upper back
Slightly More
Rounded, Neck
Slightly Forward,
Chin Slightly Out

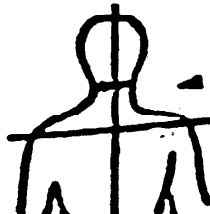


Upper back
Markedly
Rounded, Neck
Markedly
Forward, Chin
Markedly Out

HIGH SHOULDER



Shoulders Level
(Horizontally)

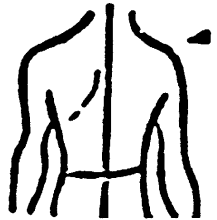


One Shoulder
Slightly Higher
Than Other

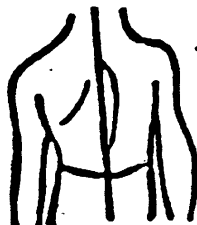


One Shoulder
Markedly Higher
Than Other

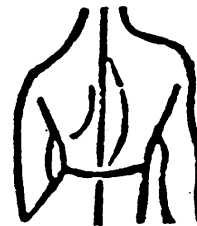
CURVED SPINE



Spine Straight

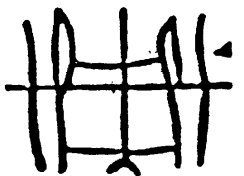


Spine Slightly
Curved Laterally



Spine Markedly
Curved Laterally

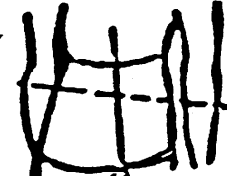
HIGH HIP



Hips Level
(Horizontally)



One Hip Slightly
Higher



One Hip
Markedly Higher

LUMBAR PROMINENCE RIB HUMP



Normal
Symmetrical



Abnormal
Asymmetrical



Normal
Symmetrical



Abnormal

PARENTAL PERMISSION FORM FOR SCOLIOSIS SCREENING

Dear Parent(s) or Legal Guardian(s):

In recent years, you may have seen an ever-increasing number of teenage girls and boys wearing neck and back braces. You may have assumed these were the result of auto accidents – but in reality, most of the children were being treated for scoliosis. Simply stated, scoliosis is an S-shaped curvature of the spine. In its early years it is painless and appears gradually, especially during the years of rapid teenage growth. It is often confused with poor posture.

Some cases of scoliosis are so mild as to need no medical attention at all. Others get progressively more severe as the child grows. If detected in its early stages during the growth years, exercises or a brace like those you have seen may be all that is needed to prevent further curvature. Unfortunately, if not detected and treated early, the curvature can become great enough to severely affect a person's appearance and health.

[704 KAR 4:020](#) "School Health Services" directs that a Scoliosis Screening Program be adopted in our schools. Scoliosis screenings are to be held in grades 6 and 8 and will be conducted by nurse(s) or trained staff or volunteers during the school day. The procedure for screening is simple; the screener looks at the child's back, standing and bent forward. Female students should wear a halter top under regular clothes, swim suit or sports bra. Male students should be prepared to remove their shirt.

A nurse will re-screen those students referred and, if further examination is indicated, you will be notified and requested to take your child to your local health care provider for further examination and x-ray.

Please sign the permission form below and return it to the school as soon as possible. (If your child is currently under treatment for a back problem, he/she does not need to participate in this screening program.)

Sincerely,

Screening Date: _____ Grade Level: _____

PERMISSION FORM

[Please check one]: () I Do () I Do Not want my child to participate in the School Scoliosis Screening Program for detecting a possible curvature of the spine.

Name of Student: _____

Signature of Parent of Legal Guardian: _____

Code: P=Passed R=Referred

[illegible]

Source: KY Dept of Education

Number Referred From Second Screening to M.D. : _____

[illegible]

REFERRAL LETTER FOR SCOLIOSIS SCREENING

Date: _____ School: _____
 Student: _____ Birthdate: _____
 Parent/Guardian: _____
 Address: _____

 Zip code: _____ Telephone: _____

Dear Health Care Provider:

During our school-screening program, the following abnormal physical findings were noted on this child: (Please be specific but brief) _____

Please schedule this child for evaluation as soon as possible.

Follow-up information from you is necessary for us to fully evaluate this screening program.

We request that you complete the section below and return this form to:

Thank you for your cooperation. If you have any questions, please feel free to call _____.

For Health Care Provider's Use Only

X-Ray Results: _____

() No significant findings at this time: _____

() Need for further evaluation: _____

() Re-examination or treatment recommended on (date): _____

() Additional Comments: _____

Date of Exam: _____

Signed: _____, M.D.

Address: _____

Zip Code: _____ Telephone: _____

HEARING SCREENING CLASS LIST

School: _____ Grade: _____

Teacher: _____ Date: _____

Instructions: List all children in the class. The information on this list should be recorded on each pupil's Cumulative Health Record.

After each child's name, place a check (✓) in the Pass column if he/she passes the hearing screening or an (X) in the Fail column if he/she fails the screening.

If the child passes the second screening test, place a check (✓) in the Pass column and draw a double line through the initial (X). If he/she fails the second screening test, place a second (X) in the Fail column.

Name of Student	Pass	Fail	Name of Student	Pass	Fail

HEARING SCREENING - FURTHER OBSERVATION LIST

Audiometer Used: _____ Calibration ANSI Tympanometer Used: _____													
Name	Remarks	Grade	Test Results								Tymp: Results	Audio Ref.	Medical Ref.
			Right				Left						
				1000	2000	4000		1000	2000	4000			

HEARING SCREENING REFERRAL

Student: _____ Age: ____ Sex: ____

Parent/Guardian: _____

Address: _____

School: _____ Grade: ____ Teacher: _____

Dear Parent or Guardian:

We have completed the hearing screening service provided as part of the School Health Program. Results of your child's hearing test indicate the need for a more complete hearing examination.

Since uncorrected hearing disorders can affect learning potential, it is important to complete this referral and return it to the school when completed.

Thank you for your cooperation. If you have any questions or if I can be of service, please contact me. _____,

School Nurse/ School Health Coordinator. Phone: _____.

Please return to:

Hearing Test Results (non-clinical testing area)

Frequency		1000	2000	4000		Remarks
Right Ear						
Left Ear						

Treatment: _____ Return advised? _____ When? _____

Health Care Provider: _____ Date: _____

Address: _____

COMMISSION FOR CHILDREN WITH
SPECIAL HEALTH CARE NEEDS

Re: School _____
 Date _____
 County _____

Dear Parent:

Your child _____, recently received a hearing screening.
 The results indicate the need for further evaluation.

It is recommended that your child be seen by a physician for an ear examination. You may wish to consult with an otologist. In any case, please take this letter to the physician who examines your child.

If you are unable to afford private care for your child, please contact your local health department or call 1-800-232-1160 for more information regarding the Commission for Children With Special Health Care Needs program in your area.

Sincerely,

Physician's Report:

Child's Name _____ BD _____ Date _____

Physician's Findings: _____

Treatment Given: _____

Recommendations: _____

Please return form to:

Parent: I agree to release the above information on my child or ward.

 Parent or Guardian's Signature

 Physician's Signature

CLASS VISION FLOW SHEET

[illegible]

VISION SCREENING REFERRAL

Student: _____ Age: ____ Sex: ____
 Parent/Guardian: _____
 Address: _____

 School: _____ Grade: ____ Teacher: _____

Dear Parent or Guardian:

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision screen indicate the need for a more complete eye examination.

Since uncorrected vision disorders can affect learning potential, it is important to complete this referral and return it to the school when completed.

Thank you for your cooperation. If you have any questions or if I can be of service, please contact me. _____,

School Nurse/ School Health Coordinator. Phone: _____.

Please return to:

Examination Results

____ Normal Exam
 ____ Amblyopia ____ Muscle Imbalance ____ Refractive Error Other _____
 ____ Myopia
 ____ Hyperopia
 ____ Astigmatism

Treatment: _____ Return advised? _____ When? _____

Health Care Provider: _____ Date: _____

Address: _____

CLASS HEIGHT / WEIGHT

Month ____ Year ____

Page ____ of ____

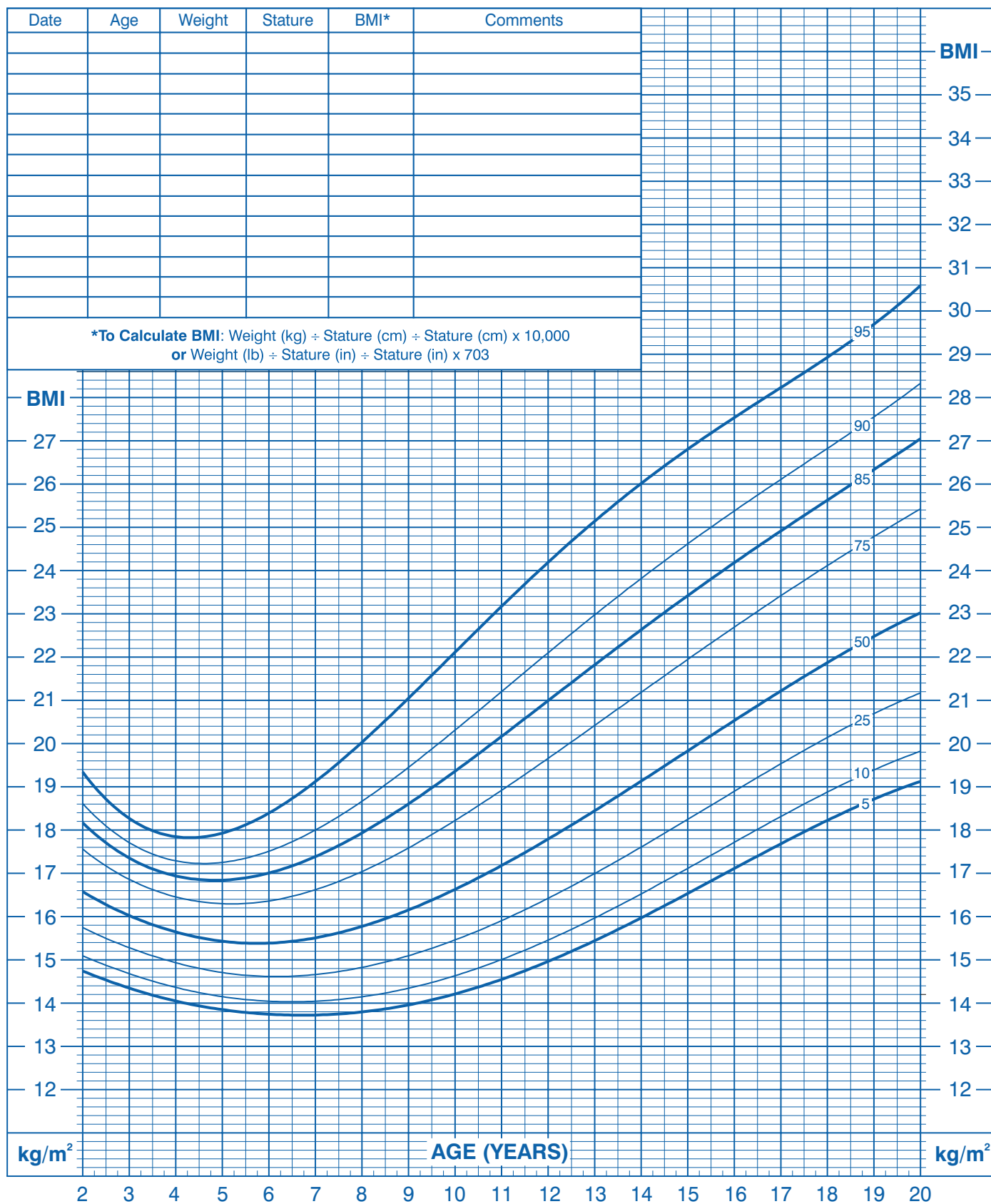
[illegible]

2 to 20 years: Boys

Body mass index-for-age percentiles

NAME _____

RECORD # _____

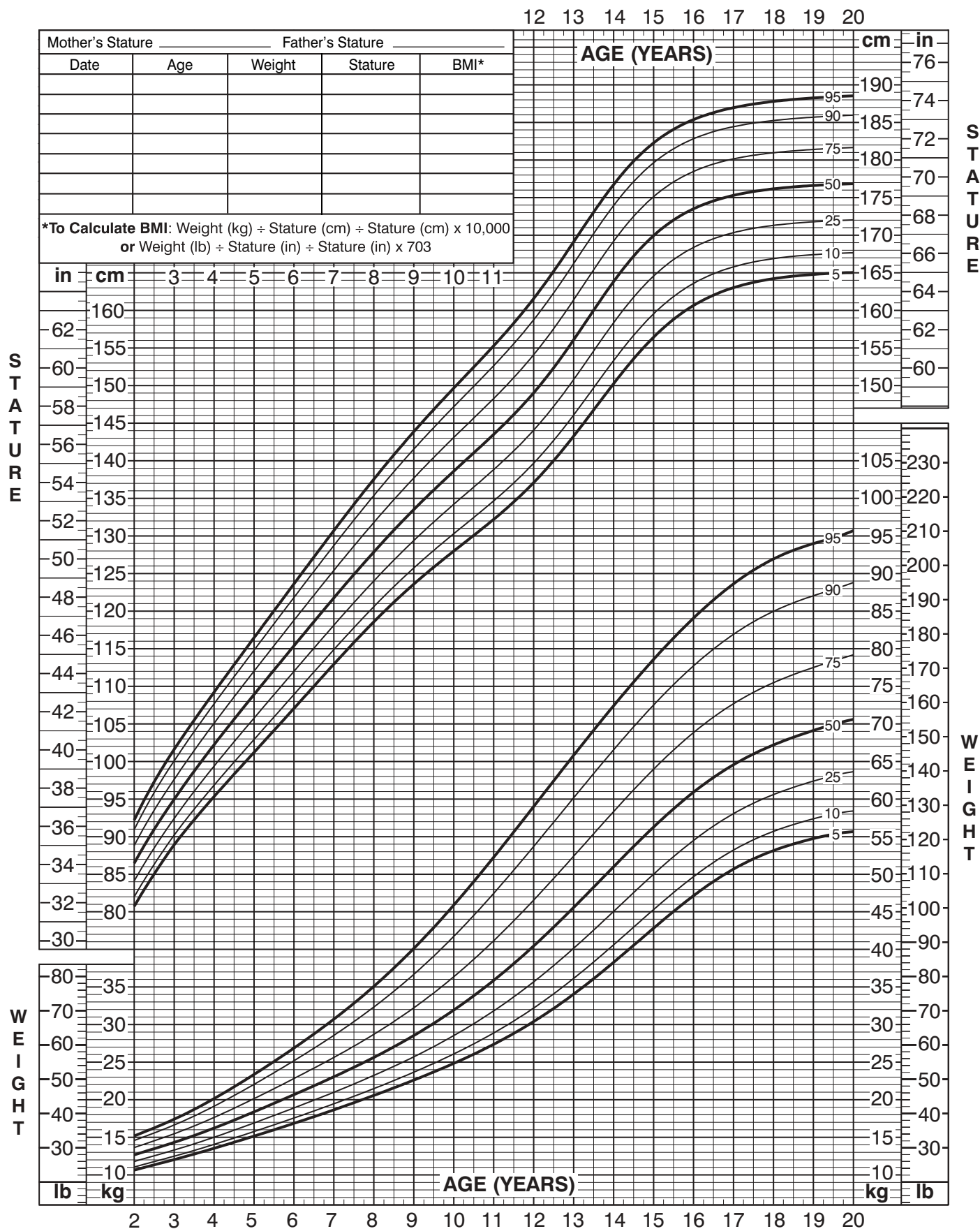


2 to 20 years: Boys

Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 11/21/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

<http://www.cdc.gov/growthcharts>

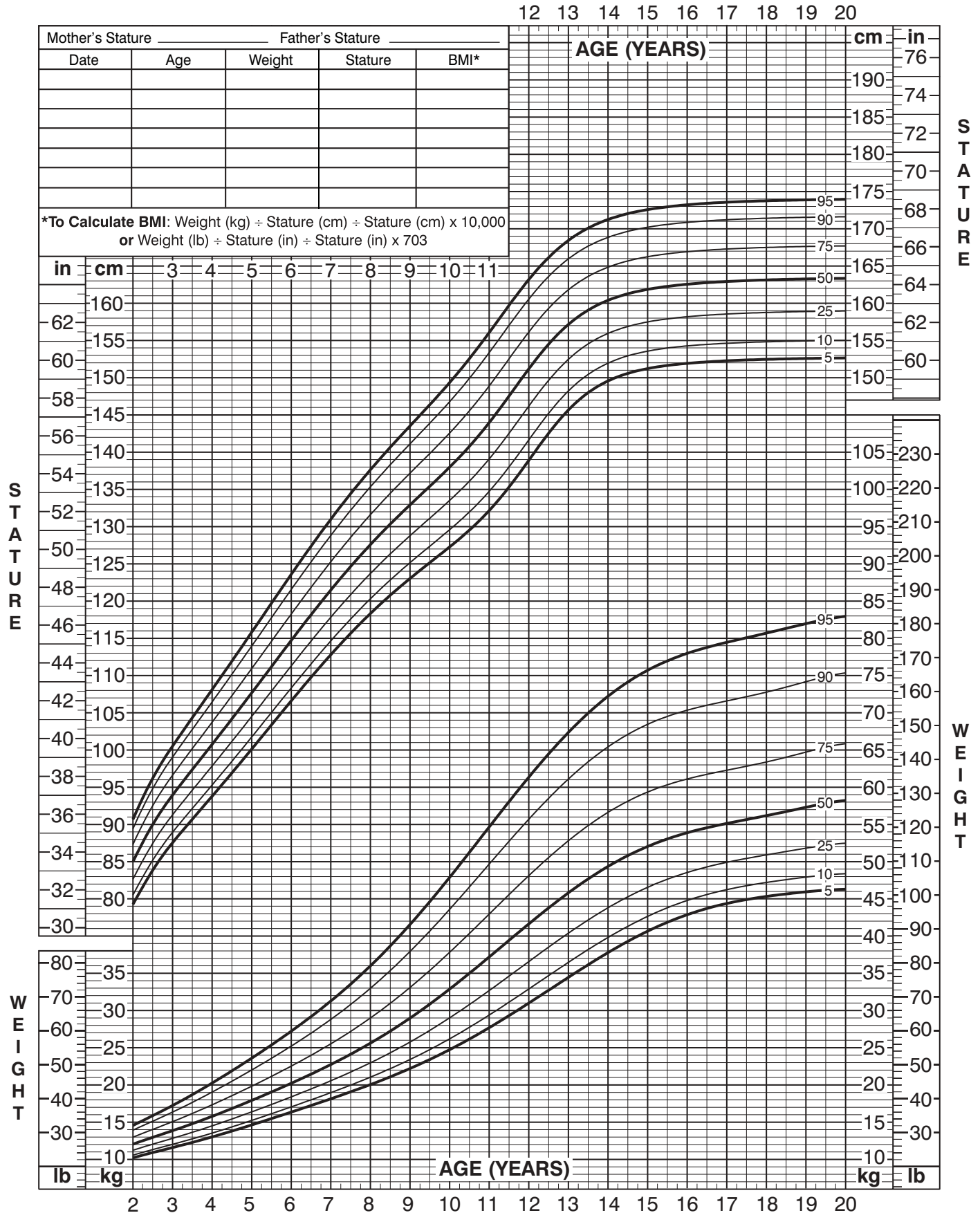
SAFER • HEALTHIER • PEOPLE™

2 to 20 years: Girls

Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 11/21/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with
the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>



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